STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

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F 0000 Bldg. 00	This visit was for the investigation of complaints IN00412806 and IN00412692. Complaint IN00412806: No Federal/State deficiencies are cited related to the allegations. Complaint IN00412692: Federal/state deficiencies related to the allegations are cited at F600, F609, and F740. Survey dates: July 12 & 13, 2023 Facility number: 000555 Provider number: 155370 AIM number: 100267530 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 4 Medicaid: 48 Other: 11 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on July 21, 2023.	F 0000	Submission of this Plan of Correction by the facility is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. Please accept the following as the facility's credible allegation of compliance.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janie Swedenburg	Administrator	07/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure resident were free from abuse for 1 of 3 residents reviewed for abuse. A resident with increased behaviors had not received psych services nor was the resident's care plan updated with a continuing intervention following a resident to resident physical altercation (Resident D), and prior to a second resident to resident physical altercation (Resident C). (Resident B, Resident C, Resident D) Finding includes: During a review of State Reportable Incidents on 7/12/23 at 10:00 A.M., an incident, dated 6/29/23, included that a resident was walking down the hall on the locked unit and turned to go in another resident's room. Resident B was in the room and made contact with the Resident D's face. During record review on 7/12/23 at 10:20 A.M., Resident B's diagnoses included but were not limited to dementia with other behavioral disturbance, insomnia, and depression. Resident B's most recent quarterly MDS (Minimum Data Set) assessment, dated 6/23/23, indicated the resident's cognition was severely	F 0600	1. The facility has taken the following corrective action(s) to address those residents and areas specifically identified as affected: A. Resident B shall be re-assessed for abuse risk upon return from the hospital. This resident shall also be placed on 1:1 monitoring to prevent risk for future incidents until this resident has evidenced that they no longer pose a risk for abuse that is sustained and ongoing. If warranted, this resident may be issued an involuntary discharge should interventions and approaches fail to eliminate Resident B's potential to abuse other residents. B. Resident C has been monitored by staff for any ongoing injury or negative outcomes. None have been noted at this time. 2. The facility has identified residents with abusive behaviors towards other peer residents as	07/24/2023

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	impaired. Resident B's physician orders included but were not limited to; Chart any unwanted behaviors from resident every shift and as needed (started 6/13/23), Aricept 5 mg (milligrams) for dementia with behavioral disturbance (started 6/9/21), and Zoloft 25 mg for depression (started 6/22/23). Resident B's care plan included Resident is physically aggressive due to anger and dementia (initiated 11/28/22). A new intervention, dated 7/4/23, included, "15 minute checks." Prior interventions were dated, 11/28/23, and included that the resident believes people are stealing his belongings. Resident has behavior problem waking his "girlfriend" up frequently and "obsessing over her" (initiated 3/14/23). No additional interventions were added following the initiation date (3/14/23). Resident is verbally aggressive and yelled at another resident that opened bed room door (initiated 6/12/23). No additional interventions were added following the initiation date (3/14/23). Resident B's progress notes included but were not limited to: 6/29/23 at 3:59 P.M. - "This afternoon resident swung fist at Resident D in the hallway for entering his room. Staff was able to intervene. Residents are now separated." 6/30/23 at 12:54 P.M. - "[Social Service Director] (SSD) spoke to resident on this day regarding [behavior] noted yesterday. Resident did not recall [behavior] but did point out other resident involved in [behavior] and told SSD to, "watch out for her." Resident otherwise appeared to be in positive mood and spirits and doing well. Resident kept separate from other resident by staff throughout the day."		having the potential to be at risk for this alleged deficient practice. These residents shall be re-assessed for abuse risk and their plans of care shall be audited to ensure that interventions and approaches are in place to address their behaviors. 3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include: A. Facility staff have been inserviced regarding the Facility's Abuse and Neglect policy. Specific discussion was given to: reporting resident behaviors that might pose risk to other residents to the DON and their appointed designee(s); utilizing effective interventions and approaches to de-escalate resident behaviors and safeguard other residents when necessary (e.g. keeping other residents away from agitated or combative resident); and immediately reporting all allegations/instances of abuse and neglect to the administrator (abuse coordinator) or the DON when the administrator is unavailable. B. The IDT has been in-serviced by the Administrator regarding the facility's abuse and neglect policy with particular emphasis placed on the issue of	

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	7/6/23 at 8:15 P.M.- "Resident was in hallway with another female resident. Resident was witnessed by CNA, grab female resident by the throat with both hands and throw her to the floor. CNA immediately separated both residents. 911 services notified for transport to [hospital], [physician] notified and updated and gave orders to send to hospital for full work up and evaluation." A 15 minute check for 72 hour period check off sheet, dated 6/30/23, indicated Resident B began "15 minute checks" on 6/30/23 at 12:00 P.M. and concluded on 7/3/23. During an interview on 7/12/23 at 1:20 P.M., the Activities Director indicated that Resident B and Resident C had a non-romantic relationship, that Resident B had never been aggressive toward Resident C before and had never been physically aggressive towards other residents until he struck a resident on 6/29/23. The Activities Director indicated that it was unclear as to why Resident B had attacked Resident C on 7/6/23, but that Resident B's behaviors had escalated prior to that incident. During an interview on 7/12/23 at 12:45 P.M., the DON (Director of Nursing) and ADON (Assistant Director of Nursing) indicated that Resident B had not been physically violent towards other residents prior to striking a Resident D, on 6/29/23, after the resident had entered a private room that Resident B was in. On 7/6/23, Resident B was observed to grab Resident C by the throat in the hallways and throw her to the ground. Resident B was immediately sent to the hospital and had since been admitted to a Geri-Psych facility. Following the incident on 6/29/2, Resident B completed a 72 hour monitoring period		**prevention** and identifying residents with behaviors that may pose risk. Discussion was given to the importance of preempting situations via effective interventions and approaches to prevent resident-to-resident altercations. 4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement: 1.The Administrator, DON and appointed designee(s) shall monitor abuse and neglect incidents/allegations to ensure that the facility's policy and procedures for Abuse and Neglect have been followed. This audit shall occur for a minimum of six (6) months or longer until substantial compliance has been achieved and is ongoing. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s).	

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	including 15 minute checks that concluded on 7/2/23. No new intervention was added to Resident B's plan of care following the 72 hour monitoring period. During an interview on 7/13/23 at 11:05 A.M., the SSD indicated that when resident to resident behavioral events occur, residents plan of care should be updated or revised and new interventions should be put into place to prevent further incidents. During an interview on 7/13/23 at 12:40 P.M., the DON (director of nursing) indicated that a geri-psych unit would not admit a resident until they physically strike another individual (Resident B had not received psych services following the incident on 6/29/23 when he struck another resident, and prior to him attacking Resident C on 7/6/23). At that time, the Administrator indicated that they believed the root cause of Resident B's most recent behaviors had to do with Resident B being over-protective of Resident C. The Administrator indicated Resident C was moved off of the secured dementia unit in attempt to stop Resident B's aggressive behaviors, but that intervention had failed due to Resident C attempting to go out the doors, and Resident C was moved back onto the dementia unit. No new new intervention was created following Resident C's return to the unit. On 7/13/23 at 1:30 P.M., the Facility Administrator supplied an undated facility policy titled, Policy and Procedure Abuse Prevention. The policy included, "...Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents... C. All staff will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of			

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	resident property is more likely to occur. This includes an analysis of: ...4. The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as resident with a history of aggressive behaviors... Protection Purpose: Protect residents from harm during an investigation. ...3. Residents a. The resident accused will be assessed by the Social Service Director and Nurse Manager for necessary action winch could include referral for inpatient psych treatment, evaluation by facility psychiatrist and/or psychologist, or routine counseling by social service director. b. Behavior management/care plan team will assess for behavior monitoring. c. Care plan will be developed as appropriate..." This Federal tag relates to complaint IN00412692. 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the			

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	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report a resident to resident physical altercation to the state agency in the required time frame for 1 of 2 resident to resident abuse incidents reviewed. Following a reportable altercation on 7/6/23, the facility did not report the incident until 7/13/23. (Resident B) Finding includes: During record review on 7/12/23 at 10:20 A.M., Resident B's nurse's notes included, 7/6/23 at 8:15 P.M.- "Resident was in hallway with another female resident. Resident was witnessed by CNA, grab female resident by the throat with both hands and throw her to the floor. CNA immediately separated both residents. 911 services notified for transport to [hospital], [physician] notified and updated and gave orders to send to hospital for full work up and evaluation." During an interview on 7/13/23 at 1:00 P.M., the Facility Administrator indicated being on a vacation at the time of the incident on 7/6/23, and	F 0609	1. The facility has taken the following corrective action(s) to address those residents and areas specifically identified as affected: A. Facility management has been trained and educated regarding the facility's Abuse and Neglect Policy. Specific discussion was given to the requirement to report all allegations of abuse and neglect to the Department of Public Health, resident's representative, resident's physician, ombudsman office, and police if the incident/allegation gives rise to a suspicion of a crime. B. Resident B shall be re-assessed for abuse risk upon return from the hospital. This resident shall also be placed on 1:1 monitoring to prevent risk for future incidents until this resident has evidenced that they no longer	07/24/2023

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	that staff had reported the incident to her, but that she was unable to report to the state agency at that time. On 7/13/23 at 1:30 P.M., the Facility Administrator supplied an undated facility policy titled, Policy and Procedure Abuse Prevention. The policy included, "...Investigation Purpose:... A. Initial Reporting 1. The Administrator or Director of Nursing (in the absence of the Administrator) will contact [state agency] and local ombudsman by telephone or fax within 24 hours to report all alleged abuse, neglect, involuntary seclusion or misappropriation of property..." This Federal tag relates to complaint allegation IN00412692. 3.1-28(c)		pose a risk for abuse that is sustained and ongoing. If warranted, this resident may be issued an involuntary discharge should interventions and approaches fail to eliminate Resident B's potential to abuse other residents. C. Resident C has been monitored by staff for any ongoing injury or negative outcomes. None have been noted at this time. 2. The facility has identified residents with abusive behaviors toward other peer residents as having the potential to be at risk for this alleged deficient practice. These residents shall be re-assessed for abuse risk and their plans of care shall be audited to ensure that interventions and approaches are in place to address their behaviors. 3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include: A. The facility has developed and implemented a new policy and procedure requiring management staff to immediately contact a member of the consultant group regarding all potential abuse/neglect occurrences when the administrator is unavailable. The management team has been	

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			inserviced regarding this new procedure. The administrator shall also contact a member of the consultant team to ensure that all procedures for abuse and neglect have been followed. B. Facility staff have been inserviced by the Administrator regarding the Facility's Abuse and Neglect policy. Specific discussion was given to: reporting resident behaviors that might pose risk to other residents to the DON and their appointed designee(s); utilizing effective interventions and approaches to de-escalate resident behaviors and safeguard other residents when necessary (e.g. keeping other residents away from agitated or combative resident); immediately reporting all allegations/instances of abuse and neglect to the administrator (abuse coordinator) or the DON when the administrator is unavailable. 4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement: 1.The Administrator, DON and appointed designee(s) shall monitor resident progress notes and behavior documentation to ensure that all instances of possible abuse and neglect have been reported the Department of	

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			Public Health and have been handled in accordance with the facility's Abuse and Neglect policy. This audit shall occur for 24 (24) consecutive weeks or longer until substantial compliance has been achieved and is ongoing. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s).	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to provide behavioral healthcare needs for 2 of 3 residents reviewed for behaviors. Residents' plan of care were not updated and continuing interventions were not put into place following multiple resident to resident behavioral incidents, and a resident's plan of care was not created following a diagnosis of depression and being ordered an	F 0740	1. The facility has taken the following corrective action(s) to address those residents and areas specifically identified as affected: A. Resident B shall be re-assessed for abuse risk upon	07/24/2023

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	antidepressant medication. (Resident B, Resident C) Findings include: 1. During a review of State Reportable Incidents on 7/12/23 at 10:00 A.M., an incident, dated 6/29/23, included that a resident was walking down hall on the locked unit and turned to go in another resident's room. Resident B was in the room and made contact with the resident's face. During record review on 7/12/23 at 10:20 A.M., Resident B's diagnoses included but were not limited to dementia with other behavioral disturbance, insomnia, and depression. Resident B's most recent quarterly MDS (Minimum Data Set) assessment, dated 6/23/23, indicated the resident's cognition was severely impaired. Resident B's physician orders included but were not limited to; Chart any unwanted behaviors from resident every shift and as needed (started 6/13/23), Aricept 5 mg (milligrams) for dementia with behavioral disturbance (started 6/9/21), and Zoloft 25 mg for depression (started 6/22/23). Resident B's care plan included Resident is physically aggressive due to anger and dementia (initiated 11/28/22). An new intervention, dated 7/4/23, included, "15 minute checks." Prior interventions were dated, 11/28/23, and included that the resident believes people are stealing his belongings. Resident has behavior problem waking his "girlfriend" up frequently and "obsessing over her" (initiated 3/14/23). No additional interventions were added following the initiation date (3/14/23). Resident is verbally		return from the hospital. This resident shall also be placed on 1:1 monitoring to prevent risk for future incidents until this resident has evidenced that they no longer pose a risk for abuse that is sustained and ongoing. If warranted, this resident may be issued an involuntary discharge should interventions and approaches fail to eliminate Resident B's potential to abuse other residents. B. Resident C has been monitored by staff for any ongoing injury or negative outcomes. None have been noted at this time. 2. The facility has identified residents with abusive behaviors toward other peer residents as having the potential to be at risk for this alleged deficient practice. These residents shall be re-assessed for abuse risk and their plans of care shall be audited to ensure that interventions and approaches are in place to address their behaviors. 3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include: A. The following measure has been taken: The IDT has been inserviced by the Administrator regarding the importance of	

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	aggressive and yelled at another resident that opened bed room door (initiated 6/12/23). No additional interventions were added following the initiation date (3/14/23). Resident B's progress notes included but were not limited to: 6/11/23 at 2:22 P.M. - Another resident opened bedroom door and Resident B became agitated and got up and slammed the bedroom door yelling, "Get out and stay out." Nurse explained to resident that she did not know any different and he said, "I don't care keep her out." 6/13/23 at 4:48 P.M. - "Resident was in dining area... and he walked up to another resident and started yelling at her. Resident was moved away from other resident, no other occurrences noted during this shift. Received order for [lab work and urinalysis with culture and sensitivity if indicated]... for possible urinary tract infection (UTI). Will continue to monitor resident for any further behaviors." 6/25/23 10:13 A.M. - "Another female resident was trying to enter room resident was in. Resident trying to shut door on resident and closed fist and put it up to female residents face. Did not strike resident. Stated 'Get the hell out of my room!' Redirected female resident to dining room and brought [Resident B] his morning medications. Took without difficulty and was pleasant with this nurse." 6/27/23 at 5:35 P.M. - "Resident was verbally aggressive with another resident. Was able to redirect resident and no further issues noted. Will continue to monitor." 6/29/23 at 3:59 P.M. - "This afternoon resident swung fist at other resident in the hallway for entering his room. Staff was able to intervene. Residents are now separated." 6/30/23 at 12:54 P.M. - "[Social Service Director]		monitoring resident behaviors and developing interventions and approaches to avert behaviors with the potential for injury to self or others. Detailed discussion was given to continually revising interventions and approaches as needed to avert resident-to-resident altercations and/or resident injury/harm to self or others. B. The following systematic change has been implemented: The leadership team shall review resident behavior documentation during the morning team meeting to identify possible resident behaviors that might require revisions to the resident's plan of care. 4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement: 1.The Administrator, DON and appointed designee(s) shall monitor resident behaviors to ensure that effective interventions and approaches are being maintained and/or implemented to prevent resident-to-resident altercations or other risk for injury to self or others. This monitoring shall also monitor that plans of care for affected residents are being revised and updated as warranted. This audit shall occur	

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	155370	A. BUILDING 00 B. WING	07/13/2023

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	(SSD) spoke to resident on this day regarding [behavior] noted yesterday. Resident did not recall [behavior] but did point out other resident involved in [behavior] and told SSD to, "watch out for her." Resident otherwise appeared to be in positive mood and spirits and doing well. Resident kept separate from other resident by staff throughout the day." 7/6/23 at 8:15 P.M.- "Resident was in hallway with another female resident. Resident was witnessed by CNA, grab female resident by the throat with both hands and throw her to the floor. CNA immediately separated both residents. 911 services notified for transport to [hospital], [physician] notified and updated and gave orders to send to hospital for full work up and evaluation." A 15 minute check for 72 hour period check off sheet, dated 6/30/23, indicated Resident B began "15 minute checks" on 6/30/23 at 12:00 P.M. and concluded on 7/3/23. During an interview on 7/12/23 at 1:20 P.M., the Activities Director indicated that Resident B and Resident C had a non-romantic relationship, that Resident B had never been aggressive toward Resident C before and had never been physically aggressive towards other residents until he struck a resident on 6/29/23. The Activities Director indicated that Resident B's behaviors had escalated recently. During an interview on 7/12/23 at 12:45 P.M. - the DON (Director of Nursing) and ADON (Assistant Director of Nursing) indicated that Resident B had not been physically violent towards other residents prior to striking a resident on 6/29/23, after the resident had entered a private room that Resident B was in. On 7/6/23, Resident B was observed to grab Resident C by the throat in the		for a minimum of six (6) months or longer until substantial compliance has been achieved and is ongoing. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s).	

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	hallways and throw her to the ground. Resident C sustained a skin tear to her right elbow when she fell to the ground. Resident B was immediately sent to the hospital and had since been admitted to a Geri-Psych facility. Following the incident on 6/29/2, Resident B completed a 72 hour monitoring period including 15 minute checks that concluded on 7/2/23. No new intervention was added to Resident B's plan of care following the 72 hour monitoring period. During an interview on 7/13/23 at 12:40 P.M., the Facility Administrator indicated Resident B's plan of care had not included monitoring the resident following a new diagnosis of dementia and an order to receive antidepressant medication Zoloft (started 6/22/23), but that it had been added to the plan of care on 7/13/23. 2. During an observation on 7/12/23 at 9:45 A.M., Resident C was lying in bed in their room fully dressed. Resident C was pleasant during an interview at that time. The resident was alert with confusion. During record review on 7/12/23 at 10:20 A.M., Resident C's diagnoses included but were not limited to dementia with behavioral disturbance, and anxiety disorder. Resident C's most recent quarterly MDS, dated 6/9/23, indicated the resident's cognition was severely impaired. Resident C's physician orders included but were not limited to; Donepezil 10 mg for dementia with behavioral disturbance (started 5/18/21), and Zoloft (antidepressant) for dementia with behavioral disturbance (started 12/3/22).			

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	Resident C's care plan included, resident has history of being physically aggressive (swatting at residents) (initiated 2/25/22). No interventions had been added to the plan of care since 5/30/23, following an incident regarding Resident C hitting another resident with her Bible. Resident C's nurses notes included the following: 6/14/23 at 5:39 P.M. - "Resident was sitting in dining room on Cardinal Unit and another resident was sitting at table next to this resident. Resident had small cup of water and threw water towards other resident. Resident then got up from table and went to her room" 6/25/23 12:36 P.M. - "[Resident] in dining room eating lunch. Male resident next to [Resident C] and trying to take stuff off her tray. Attempted to redirect male resident, unsuccessful. Male resident tried to do it again. [Resident C] became increasingly agitated and started yelling at male resident. [Resident C] took her tray and shoved it at other resident. Tray with food went all over male resident and floor and plate broke. Staff removed male resident from situation to change clothes and [Resident C] went down the hallway to her room." 7/8/23 at 1:59 P.M. - "Heard another resident hollering for help. Found in [Resident C's] room stating she was hitting her. When asked [Resident C] if she hit other resident. Stated 'Yes, I hit her and I will do it again. She needs to stop and get out of here.' Explained to resident that this was inappropriate behavior..." During an interview on 7/13/23 at 11:05 A.M., the SSD indicated that when resident to resident behavioral events occur, residents plan of care should be updated or revised and new			

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	interventions should be put into place to prevent further incidents. On 7/13/23 at 1:30 P.M., the Facility Administrator supplied an undated facility policy titled, Behavior Management - Clinical Protocol. The policy included, "Assessment and Recognition ...4. For new and worsening behaviors, the nurse shall assess and document/ report the following: ...i. Any recent medication changes... m. Interventions attempted to alleviate behavioral symptoms, both pharmacological and non-pharmacological... 1. The staff will use protocols to identify pertinent interventions, other than medications, for the nature and causes of the individual's problematic behavior. Review 1. New and worsening behaviors will be reviewed by the IDT (intra-disciplinary team) the following business day for: ...f. New interventions targeted to the behavior... h. updating of care plan... Monitoring ...5. The nursing staff and the Physician will monitor for side effects and complications related to psychoactive medications..." This Federal tag relates to complaint IN00412692. 3.1-37(a)			